History and Physical

Auto Basophils %	0.5 %
Auto Neutrophils Absolute #	**14.2 x10^3/mcL HI**
Immature Granulocyte Absolute #	**0.24 x10^3/mcL HI**
Auto Lymphocytes Absolute #	**4.1 x10^3/mcL HI**
Auto Monocytes Absolute #	0.6 x10^3/mcL
Auto Eosinophils Absolute #	0.37 x10^3/mcL
Auto Basophils Absolute #	0.1 x10^3/mcL
MCV	95.4 fL
MCH	30.9 pcg
MCHC	32.4 %
RDW	12.4 %
RDW-SD	43.6 fL
MPV	10.0 fL
PT	**16.3 sec HI**
INR	1.3 NA
Ethanol Level	<.010 %
Ethanol Level mg/dL	<10 mg/dL
Blood Type	A POS
Blood Type Confirm	A POS

Radiology Impressions:

COMPLETED RADIOLOGY IMAGING STUDIES:

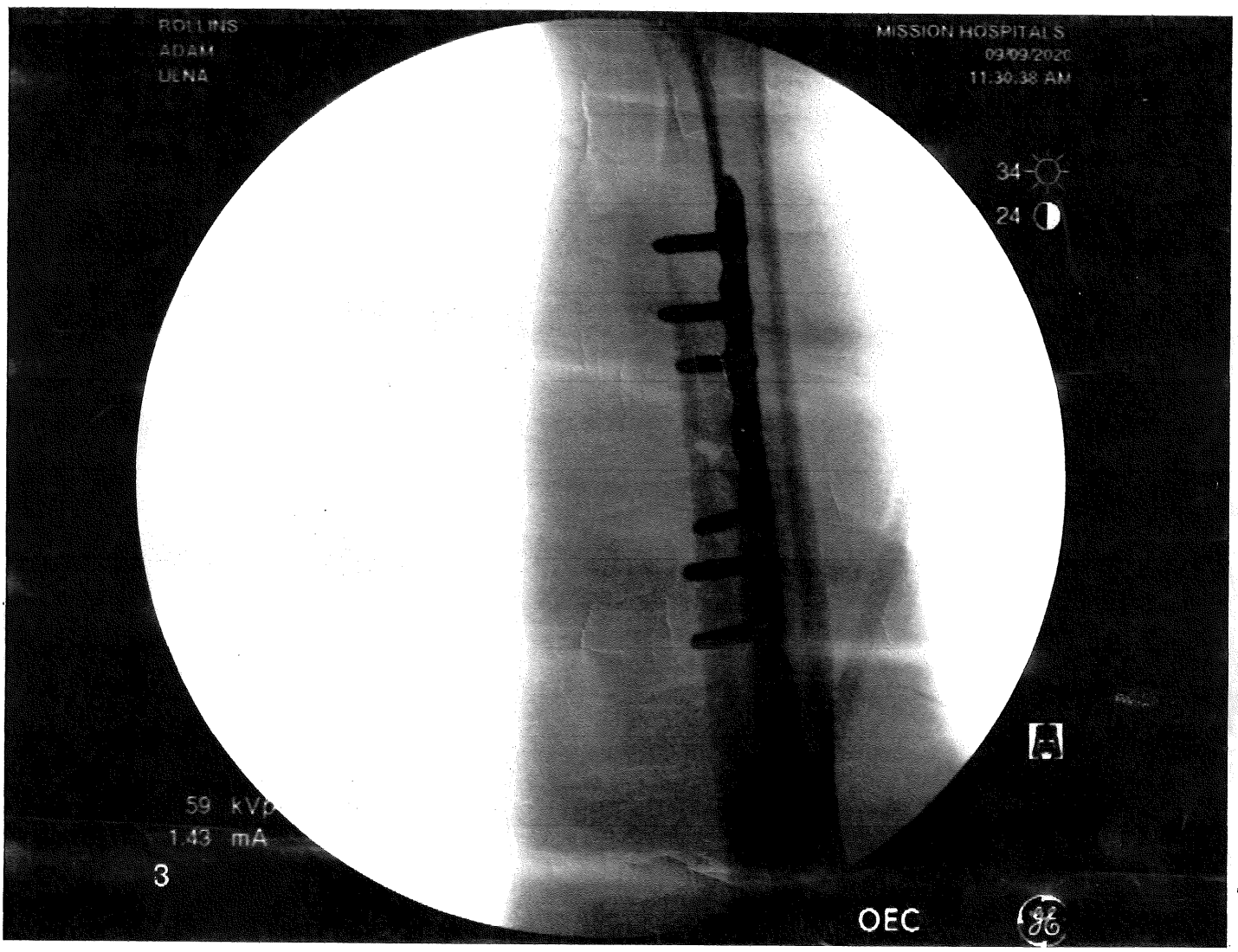
DX Portable Chest
(09/08 0233): 1. There is a left basilar pneumothorax and extensive subcutaneous air. 2. Left scapular fracture with associated chest wall hematoma and packing material in place.

CT Recon Pelvis
(09/08 0150): 1. No fracture. 2. Extensive left-sided posterior abdominal wall hematoma and subcutaneous air tracking down from the chest wall. 3. Small hematoma adjacent to the greater trochanter as well as some subcutaneous air in that location.

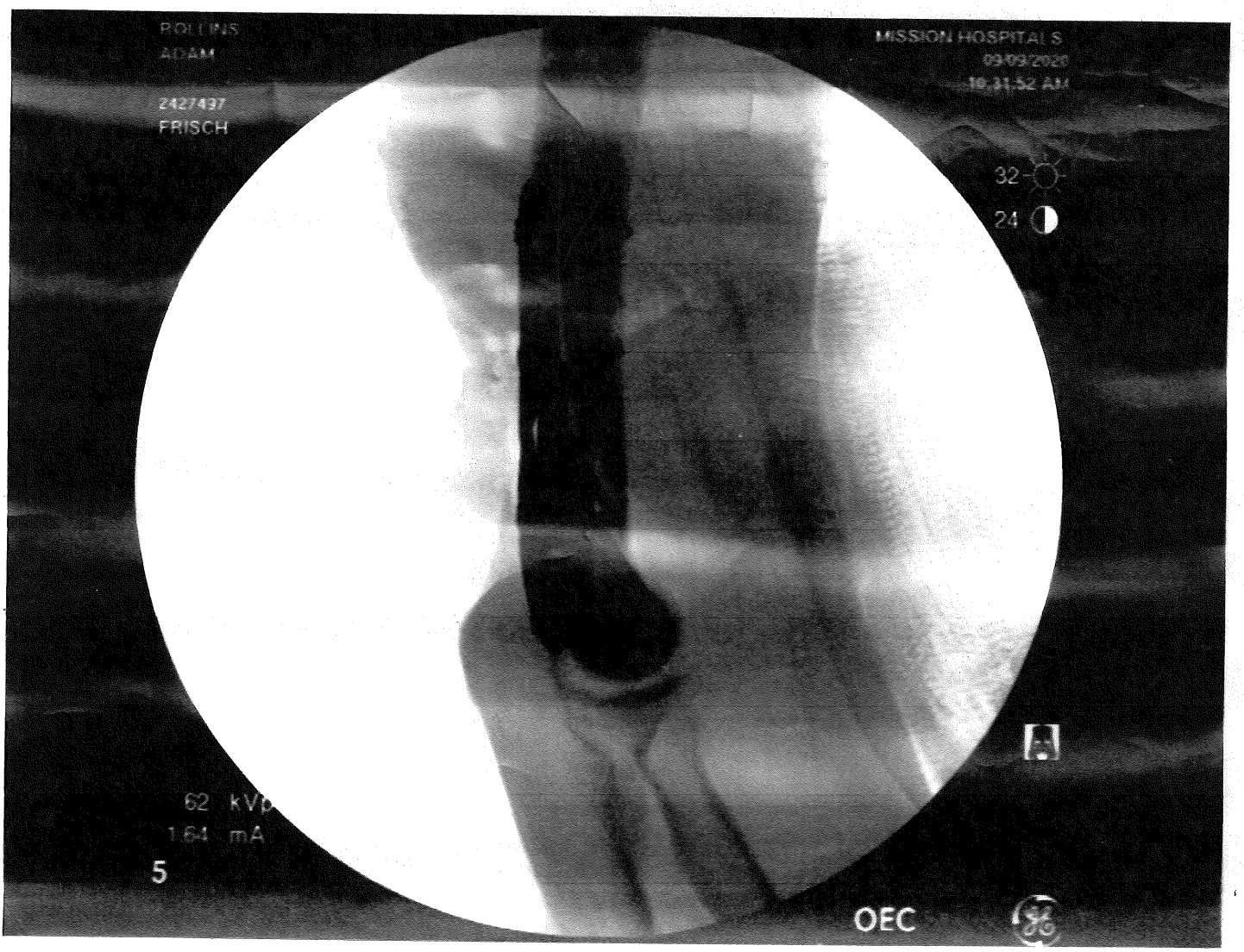
CT Thoraco Lumbar Recon
(09/08 0158): 1. No thoracic or lumbar spine fractures identified. 2. Large left-sided pneumothorax.

Exhibit of tire print

These medical records are approx 30 pages out of a total of approx 1500 pages



ROLLINS
ADAM
242497
FRISCH
MISSION HOSPITALS
OEC
62 kVp
160 mA
2
31
25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09/09/2020
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32
24
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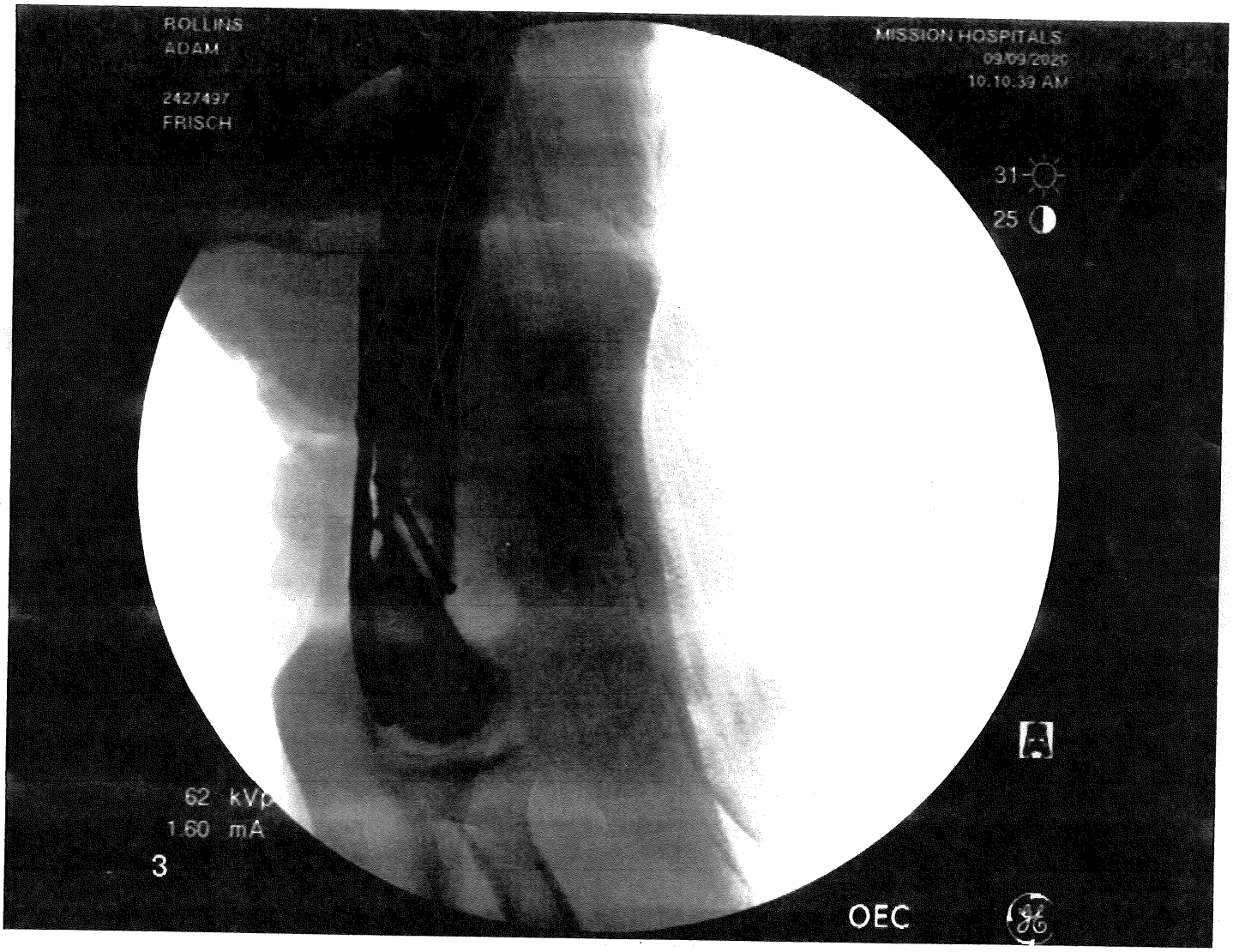
5
OEC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31
25
62 kVp
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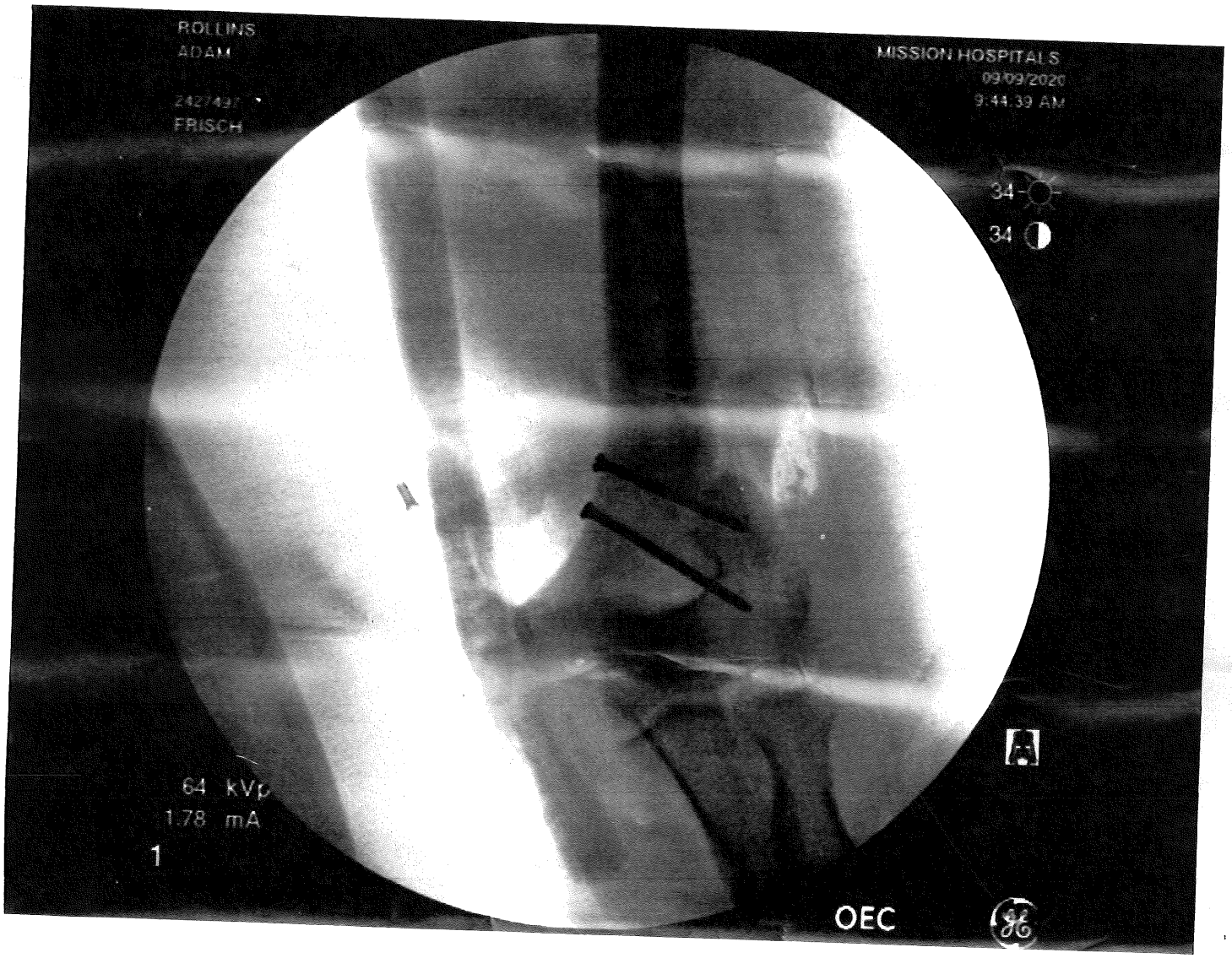
3
OEC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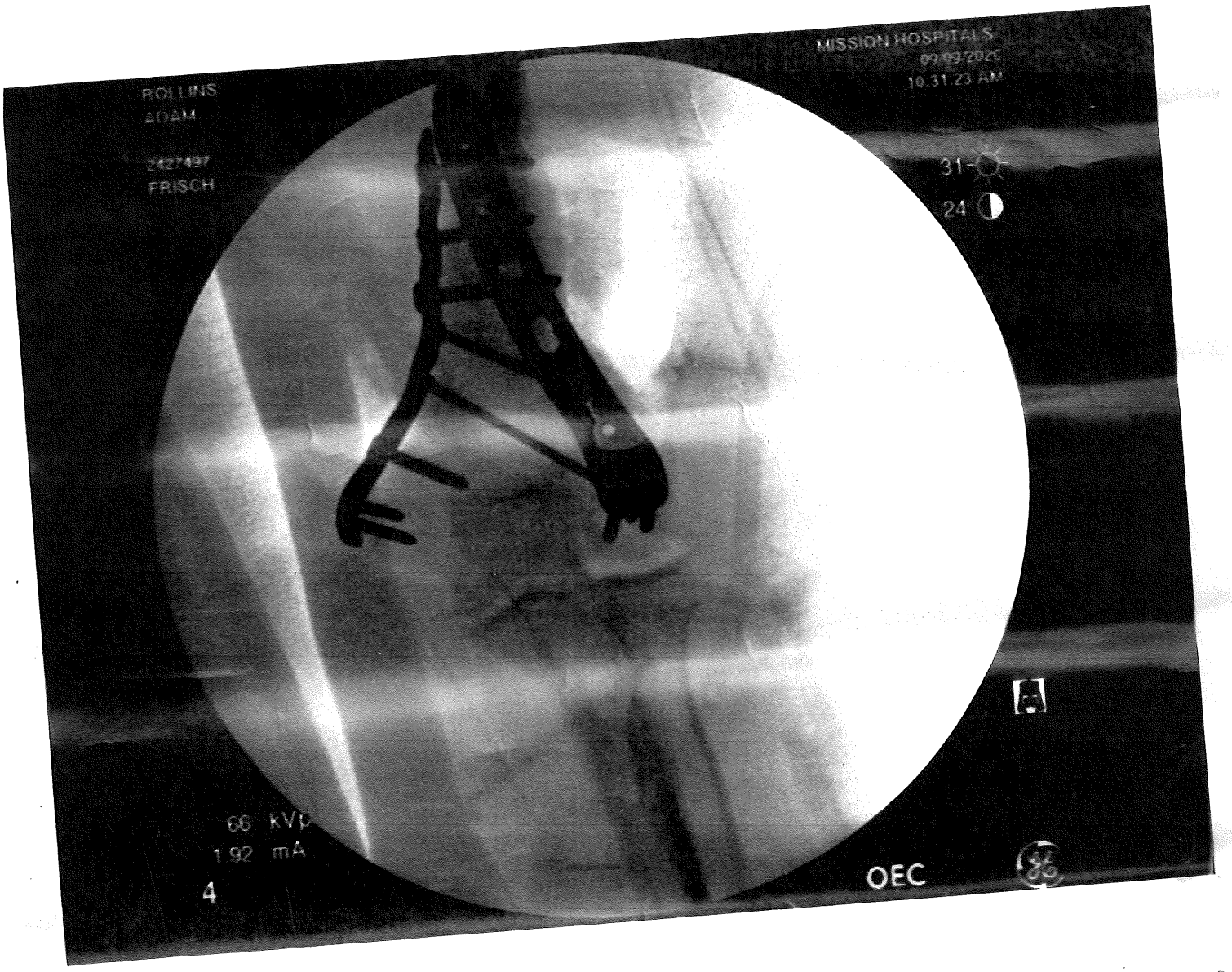
34
64 kVp
1.78 mA
1
OEC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09/09/2020
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ADAM
2427497
FRISCH
31
24
66 kVp
1.92 mA
4
OEC

History and Physical

SIGN INFORMATION: Griffin MD[S],Lance W (9/8/2020 06:59 EDT); Morris MD[R], Rachel E (9/8/2020 05:29 EDT)

SERVICE DATE/TIME: 9/8/2020 00:35 EDT

Addendum by Griffin MD[S], Lance W on September 08, 2020 06:59 EDT
I examined the patient in the emergency department upon arrival for code trauma activation -I was present prior to the patient's arrival. Patient was hemodynamically unstable with need for resuscitation. He had an intact airway and was breathing adequately. However, given the nature of the patient's left chest injuries and questionable breath sounds and empiric chest tube was placed. Patient had a notably large amount of ecchymosis, superficial burn and palpable emphysema to the left chest as well as protruding muscle from the posterior left chest. CT scan was obtained after we resuscitated the patient with massive transfusion. This was significant for a severe left scapular and subcutaneous tissue injury. There was no signs of active extravasation on angiography, however, there was ongoing bleeding coming from the soft tissue cavity. This was controlled with application of 3 Z-fold portions of quick clot that were tied together. Following this, silk suture was used to tightly close the skin over the wound to allow for further compression. Fluid resuscitation and blood resuscitation continued in the emergency department until patient was more stable and he was transferred to the neurotrauma ICU in severely critical condition.

I spent 120 minutes of total critical care time personally at the bedside in the emergency department and the neurotrauma ICU. This was in addition to any teaching time that was spent during this encounter. My critical care time involved in direct bedside patient care and care coordination with all other providers. The patient is critically ill secondary to acute mixed hypercapnic and hypoxic respiratory failure in the setting of hemorrhagic shock secondary to massive polytrauma.

Lance Griffin, MD

Signed on 09/08/2020 06:59 by
Griffin MD[S], Lance W, MD

Trauma Admission H&P

Patient: **CTIOWA, ONE** **MRN: 00-02-42-74-97** **FIN: 292408200232**
Age: **28 years** Sex: **Male** DOB: **10/20/1991**
Associated Diagnoses: **None**
Author: **Morris MD[R], Rachel E**

Basic Information
Physician Copies:

History limitation: Clinical condition.

Chief Complaint

History and Physical

TRAUMA

History of Present Illness

30-ish year old M s/p motorcycle collision with stationary vehicle presenting at CTIOWA to Trauma bay. Patient arrived via EMS, intubated, sedated. Reportedly struck at parked cop car earlier today at high speeds. Patient was reportedly GCS 13 at the scene per EMS. He was noted to have "protruding lung" on the left chest and was intubated for transport. Additionally was noted to have crepitus along the entire left side of the thorax/abdomen to the level of the left hip. Received Ketamine, versed, and succinyl choline for RSI. Additional meds included 150 mcg of fentanyl. On arrival, patient was hemodynamically stable with SBP in 140s. Primary survey revealed equal breath sounds with CXR notable for no obvious PTX. Patient became acutely unstable with hypotension, tachycardia noted. His left chest was decompressed emergently given this concern. A Cordis was placed in the L SCV emergently for access. MTP initiated and patient received 6u RBC, 6u FFP during resuscitation and transport to CT scanner subsequently. A right femoral aline was additionally placed for continuous monitoring.

No lung was noted to be protruding, however there was a posterior laceration overlying the left scapula with exposed muscle which was noted to be oozing a significant amount of blood. QuickClot was packed into the wound. After CT, this was still actively bleeding and the wound was repacked with 3 Z packs of QuickClot tied together and the skin reapproximated using silk in a running, locked fashion.

No additional history able to be obtained given patient's intubation/sedation status.

Review of Systems

UTA given patient condition

Health Status

Allergies: UTA given patient condition
Current medications: UTA given patient condition

Histories

UTA histories (medical, surgical, family, social) given patient condition

Physical Examination

VS/Measurements:
No qualifying data available.
General: Intubated, sedated
Eye: Normal conjunctiva, PEERL
HENT: Normocephalic, laceration to scalp, left periorbital swelling, ecchymosis
Neck: In c-collar, no obvious deformities
Neurological: GCS3T with sedation, no obvious deficits

History and Physical

Cardiovascular: Tachycardic with regular rhythm, no cyanosis, clubbing, or edema. Chest wall stable
Pulmonary: Intubated, crepitus overlying entire left side/flank to hip
Gastrointestinal: Soft, non-distended
Musculoskeletal: Obvious deformity of the LUE.
Integumentary: Superficial partial thickness burn to the abdomen, left thigh. Multiple lacerations including to left elbow x2 (~2cm), left hip, scalp, posterior left chest
Psychiatric: Unable to assess

Review / Management

Laboratory Results Review: Today's Lab Results : LABORATORY RESULTS

09/08/2020 00:05 EDT

Sodium	136 mmol/L
Potassium	**3.0 mmol/L CRIT**
Chloride	108 mmol/L
CO2, Total	**14 mmol/L LOW**
Anion Gap	14.0 mmol/L
Glucose, Serum	**272 mg/dL HI**
BUN	10.0 mg/dL
Creatinine	**1.13 mg/dL HI**
Calcium	**7.6 mg/dL LOW**
Calcium, Corrected	8.6 mg/dL
Protein, Total	**4.9 g/dL LOW**
Albumin, Serum	**2.80 g/dL LOW**
Bilirubin, Total	0.40 mg/dL
Alkaline Phosphatase	42 intl unit/L
ALT	**61 intl unit/L HI**
AST	**112 intl unit/L HI**
Osmolality (Calculated)	281 mOsm/kg
WBC Count	**19.6 x10^3/mcL HI**
RBC	**4.11 x10^6/mcL LOW**
Hemoglobin	**12.7 g/dL LOW**
Hematocrit	39.2 %
Platelet Count	208 x10^3/mcL
Auto NRBC	0.0 /100WBC
Auto Segmented Neutrophils %	72.5 %
IG%	**1.2 % HI**
Auto Lymphocytes %	21.0 %
Auto Monocytes %	**2.9 % LOW**
Auto Eosinophils %	1.9 %

History and Physical

CT Thorax/Abd/Pelvis W/ Cont
(09/08 0140): 1. A large left basilar pneumothorax and associated atelectasis with a left chest tube in place. 2. There is a comminuted left clavicle fracture with associated large hematoma and packing material noted posteriorly. 3. Subcutaneous air extends down the left chest wall as well as anterior abdominal wall to the left groin. 4. There is a left buttocks hematoma posterior lateral to the left hip with some subcutaneous air in the posterior lateral soft tissues.

CT Face W/O Contrast
(09/08 0135): 1. Depressed left orbital floor fracture approximately 3 mm. 2. Thickened and sclerotic sphenoid bone more prominent on the right perhaps on the basis of fibrous dysplasia.

CT Cervical Spine W/O Contrast
(09/08 0148): 1. Sclerotic and sphenoid bone most compatible with fibrous dysplasia. 2. Comminuted scaphoid fracture with extends and surrounding hematoma and subcutaneous air. 3. No cervical spine fracture.

CT Head W/O Contrast
(09/08 0131): 1. Left periorbital soft tissue swelling with irregularity of the floor the orbit suspicious for an orbital floor fracture. 2. There is a sclerotic appearance to the sphenoid bone.

DX Portable Chest
(09/08 0001): 1. Prominent subcutaneous air on the left suspicious for a left basilar pneumothorax.

Documentation reviewed: Records from referring facility, Records from referring physician, Reviewed prior records, Flowsheet, Reviewed home medications.
Condition: Stable.

Impression and Plan
30-ish yo M presenting as CTIOWA Code Trauma s/p motorcycle vs. stationary vehicle

Acute Problem List:
#Left posterior chest laceration with muscle protrusion - packed with 3 packs Z QuickClot tied together, running locked silk closure to open wound
#Left basilar PTX
#Left comminuted clavicular frx, associated hematoma
#Left buttock hematoma
#Left scapular frx
#Left proximal and mid-distal ulnar frx

History and Physical

#Left distal comminuted humeral frx
#Comminuted scaphoid fracture with associated hematoma
#Superficial, partial thickness burn to LLE - 2%
#Superficial, partial thickness burn to abdomen - 7%
#Left-sided chest/abdomen crepitus
#Scalp laceration
#Laceration of L elbow x2 (~2cm each)
#Laceration of L posterior ankle
#Left orbital floor frx, depressed 3mm
#Hypokalemia
#Hypocalcemia
#Coagulopathy s/t trauma
#Leukocytosis, reactive
#Hyperglycemia
#AKI

Neuro:
-- S/p rocuronium, Versed in ED
-- Start prop/fent gtt for sedation in ICU
-- Daily sedation holiday

CV: R femoral a-line in place
-- Continuous EKG monitoring
-- L SCV Cordis in place for resuscitation

Pulm:
-- Intubated, ventilated
-- Daily SBT
-- Chlorhexidine wash
-- L chest tube to -20mmHg suction
-- Dressing: reinforce as needed
-- ?2nd chest tube

FEN/GI:
-- NPO, OGT in place
-- IVF
-- Monitor BMP daily. Replace electrolytes PRN

History and Physical

GU: Foley in place, Cr 1.13
-- Continue strict ins/outs

Heme: H/H stable

ID: s/p Rocephin, tdap
-- Rocephin qd given wounds
-- Monitor CBC daily

MSK/Skin:
- Bacitracin to burns
- Ortho c/s for fractures

Endo: no concerns at this time

Prophylaxis:
-- DVT: Currently holding in setting of ongoing active bleeding. SCDs.
-- GI: H2 blocker

Lines/Tubes: L SCV, R femoral aline, PIV x3, Foley

Disposition: admit to trauma, ICU status, anticipate greater than 2 midnight stay
Code Status: FULL CODE

Signed on 09/08/2020 05:29 by
Morris MD[R], Rachel E, Resident

Consultation

SIGN INFORMATION: Helgeson MD[S],Ashley P (9/8/2020 13:42 EDT)
SERVICE DATE/TIME: 9/8/2020 13:28 EDT

Cardiovascular Consultation H&P

Patient: **CTIOWA, ONE** **MRN: 00-02-42-74-97** **FIN: 292408200232**
Age: **28 years** Sex: **Male** DOB: **10/20/1991**
Associated Diagnoses: **None**
Author: **Helgeson MD[S], Ashley P**

Consultation

Basic Information
Physician Copies: Helgeson MD[S], Ashley P.
Source of history: Family member, Medical record, Not self.
Referral source: Griffin MD[S], Lance W.
History limitation: None.

Chief Complaint
Cardiology consultation is requested by Dr. Griffin for the evaluation of troponin positivity.

History of Present Illness
CT I will 1 is a 28-year-old gentleman admitted as a code trauma. The patient was the driver of a motorcycle that struck a parked vehicle at a high rate of speed leading to dynamically unstable left pneumothorax status post chest tube placement, left orbital fracture, open left scapular fracture, left clavicular fracture, and extensive soft tissue trauma.

On presentation, he required intubation due to respiratory compromise from his pneumothorax. He remained hypotensive and tachycardic. He required aggressive volume resuscitation. His initial troponin was 1.4 without a repeat. Lactate was 2.9 with a repeat of 1.7. Hemoglobin was initially 12.7 subsequently declining to 7.7 with concern for active peritoneal bleeding?.

Cardiology was consulted for positive troponin.

Echocardiogram from September 8, 2020 (images reviewed and interpreted). LV function is grossly normal with preserved RV function and no significant valvulopathy. Trivial pericardial effusion without evidence of cardiac tamponade.

EKG (reviewed and interpreted) demonstrating normal sinus rhythm, normal axis, normal intervals, nonspecific ST segment changes.

Review of Systems
unable to obtain due to intubation/ sedation and clinical condition.

Health Status
Medications:
Medications (20) Active
Scheduled: (13)
.Placeholder Bowel Elimination Orders 1 each, Misc, As Directed
.Placeholder Calcium Replacement Adult Plan 1 each, Misc, As Directed

Consultation

.Placeholder Emergency Treatment Adult Protocols Medication 1 each, Misc, As Directed
.Placeholder Phosphorus Replacement Adult Plan 1 each, Misc, As Directed
.Placeholder Potassium/Magnesium Replacement Medications 1 each, Misc, As Directed
bacitracin oint tube 15 g 1 applTn, Topical, BID
Colace liq 100 mg/10 mL ud 100 mg 10 mL, Tube, BID
Lidoderm patch 5% 2 patch, Transdermal, Apply at HS + remove in AM
Pepcid vial 20 mg/2 mL 20 mg 2 mL, IV Push, BID
Peridex unit dose oral rinse 15 mL 15 mL, PO (by Mouth), BID
Peridex unit dose oral rinse 15 mL 15 mL, Swish & spit, BID
Rocephin inj 1 g 1 g 9.8 mL, IV Push, Q24HR
Senokot syrup 8.8 mg/5 mL 15 mL U/D cup 17.6 mg 10 mL, Tube, BID
Continuous: (3)
fentaNYL IV infusion 1,250 mcg + Premix Diluent 50 mL 50 mL, IV
Lactated Ringers 1,000 mL 1,000 mL, IV, 175 mL/hr
midazolam IV infusion 50 mg + Premix Diluent 50 mL 50 mL, IV
PRN: (4)
Haldol inj 5 mg/mL 5 mg 1 mL, IV Push, Q3HR
SEROquel tab 25 mg 25 mg 1 tab, Tube, Q6HR
Ultram tab 50 mg 25 - 50 mg, Tube, Q6HR
Versed inj 2 mg/2 mL 2.8 mg 2.8 mL, IV Push, Q10M

No qualifying data available

Histories

Past Medical History: Problem List
No qualifying data available.
none.
Family History:
No family history recorded.
noncontributory.
Social History:
Tobacco
Details: Unknown if ever smoked

Physical Examination

General: No acute distress, traumatic injuries involving L-upper extremity., Not alert and oriented.

Consultation

HENT: Normocephalic.
Neck: Supple, Non-tender, No thyromegaly.
Cardiovascular: No murmur.
Palpation: No RV lift, non-displaced PMI, No RV lift, non-displaced PMI, No RV lift, non-displaced PMI.
Rate: Tachycardia.
Rhythm: Regular.
Gallop: None.
Jugular venous distention: Absent.
Edema: Absent.
Vascular:
Carotid: Bilateral, 2+, No bruit.
Carotid: Bilateral, 2+, No bruit.
Radial: Bilateral, 2+.
Radial: Bilateral, 2+.
Femoral: Bilateral, 2+.
Femoral: Bilateral, 2+, 1+.
Posterior tibial: Bilateral, 2+.
Posterior tibial: Bilateral, 2+.
Dorsalis pedis: Bilateral, 2+.
Dorsalis pedis: Bilateral, 2+.
Abdominal: No bruit, No pulsatile.
Musculoskeletal: No tenderness.
Respiratory: Coarse, mechanical breath sounds bilaterally.
Respirations: Tachypneic, Shallow.
Gastrointestinal: Soft, No palpable masses. Hypoactive BS. Soft. Non-distended..
Genitourinary: No costovertebral angle tenderness.
Lymphatics: No lymphadenopathy neck, axilla, groin.
Integumentary: Warm, Intact.
Neurologic: Not alert, Not oriented.
Cognition and Speech: UNable to assess orientation or speech due to ventilator and sedation.
Psychiatric: Unable to assess due to sedation and ventilation, Not cooperative, Not appropriate mood & affect.

Review / Management
Laboratory Results Review:
Labs (Last four charted values)

WBC		5.9	(SEP 08)	11.2	(SEP 08)	H **19.6**	(SEP 08)	
Hgb	L **7.7**	(SEP 08)	L **11.7**	(SEP 08)		L **10.8**	(SEP 08)	L **12.7** (SEP 08)

Attachment(s): 9/7/2020 22:48 EDT ESO Solutions Run Sheet - D0F77677-CC7D-450A-8D22-80D2B63F505B

Henderson County EMS
Patient Care Record

Name: ROLLINS, ADAM **Incident #:** 20081887 **Date:** 09/07/2020 Patient 1 of 1

Section II - Authorized Representative Signature

Complete this section only if the patient is physically or mentally unable to sign.
Authorized representatives include only the following:(Check one)

Patient's Legal Guardian
Patient's Medical Power of Attorney
Relative or other person who receives benefits on behalf of the patient
Relative or other person who arranges treatment or handles the patient's affairs
Representative of an agency or institution that provided care, services or assistance to patient

I am signing on behalf of the patient to authorize the submission of a claim for payment to Medicare, Medicaid, or any other payer for any services provided to the patient by the transporting ambulance service now or in the past or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below. **My signature is not an acceptance of financial responsibility for the services rendered.**

Signature

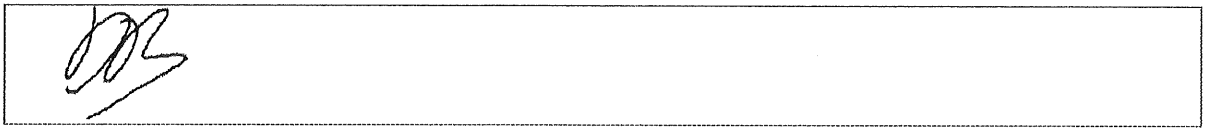
Signed On	
Printed Name	
Reason unable to sign	

Section III - EMS Personnel and Facility Signatures

Complete this section if the patient was mentally or physically incapable of signing, and no Authorized Representative (section II) was available or willing to sign on behalf of the patient at the time of service.

EMS Personnel Signature

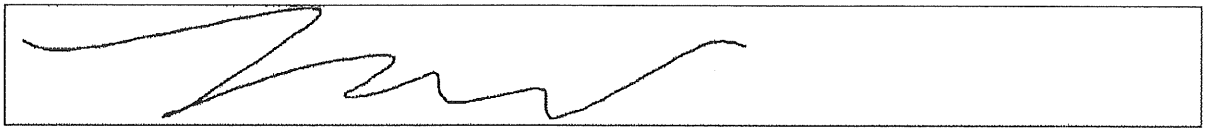
My signature below indicates that, at the time of service, the patient was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient's behalf. **My signature is not an acceptance of financial responsibility for the services rendered.**



Signed On	09/08/2020 00:21:48
Printed Name	Doug Bonnoitt
Reason unable to sign	Code trauma

Facility Representative Signature

The patient named on this form was received by this facility on the date and at the time indicated and this facility furnished care, services or assistance to the patient. **My signature is not an acceptance of financial responsibility for the services rendered.**.



Signed On	09/07/2020 23:48:27
Notice of Privacy Practices Provided	Yes
Printed Name	Ryan
Title of Representative	ED RN

*** Auth (Verified) ***

Mission Hospital
509 Biltmore Ave
Asheville, NC 28801

Mission Hospital System
Date Finalized: 9/8/2020 16:30

CTIOWA, ONE
00-02-42-74-97
M-2020-17548
Laparotomy , Thorecotomy

Name:	CTIOWA, ONE	OR	MDR 34	Case #:	M-2020-17548	MRN:	00-02-42-74-97	Allergies:	
Surg. Date:	9/8/2020 14:35	Age	28 years			FIN NBR	292408200232	Height	180.3 cm
Surgeon:	Kopelman MD[S], Tammy R Kopelman MD[S], Tammy R	Anesthesiologist	Cho MD[S], Michael Archambault MD[S], Francois J	ASA Class:	4E Emergency Severe Disease Life at Risk	Pre-Op Dx	Abdominal trauma	Weight	70 kg
Beta Blocker:		Anes. Type:	General Anesthesia	STOP-Bang Score:		Procedure:	Laparotomy , Thorecotomy	Body Mass Index	21.5 kg/m2
Beta Blocker Dose Time:						Surgeon Comments:	Laparotomy - Placement of Abthere negative pressure dressing, Thoracotomy - Placement of 2nd chest tube		

Medications

Gases

Intake

Output

Monitors

Personnel

Provider
Waldroup CRNA, Amber 14:20- 16:23

Supervisor
Archambault MD[S], Francois J 14:20- 15:04
Cho MD[S], Michael 15:05- 16:23

Signed By
Waldroup CRNA, Amber 15:11 9/8/2020
Archambault MD[S], Francois J 14:29 9/8/2020
Cho MD[S], Michael 15:05 9/8/2020

*** Auth (Verified) ***

Mission Hospital 509 Biltmore Ave Asheville, NC 28801	Mission Hospital System Date Finalized: 9/8/2020 16:30 Page 3 of 4	CTIOWA, ONE 00-02-42-74-97 M-2020-17540 Laparotomy, Thoracotomy

Actions

9/8/2020
14:20In Situ Lines/Tubes
Peripheral IV: Right
Peripheral IV: AC
Arterial Line: Right
Arterial Line: Femoral
CVL: Left
CVL: Subclavian
Chest Tube: Left
Anesthesia Start Time
Vital Sign: SpO2 - 10
In Situ Airway
Airway: Oral ETT
Size: _ Size - 8
Placement Verified: BSEB
Placement Verified: Equal Chest Expansion
Placement Verified: ETCO2 Present
14:22Patient in Room Time
14:27Thermoregulation
Temperature Monitoring: Nasal Pharyngeal
Bair Hugger Warming #1: Lower Body
Bair Hugger Setting #1: 43°
Fluid Warmer: x 1
Other Warming Measures: Warm Blankets
14:30Positioning
Body Position: Supine
Head: Gel Donut
Eyes: Right
Eyes: Bilateral
Eyes: Free From Pressure
Eye Tape: Taped PreAirway Mgt
Eye Tape: Opsite
Neck: Neutral
Right Arm: Abduction < 90°
Right Arm: On Elevated Armrest
Right Arm: Armboard Restraint
Left Arm: Abduction < 90°
Left Arm: On Elevated Armrest
Left Arm: Armboard Restraint
Right Leg: Straight
Right Leg: Pressure Points Padded
Left Leg: Straight
Left Leg: Pressure Points Padded
Additional: Pressure Points Padded
Additional: Breasts Free from Pressure
Additional: Genitals Free from Pressure
Additional: Ears, Nose, Chin free of Pressure
Repositioning: Head/Neck/Body Neutral during Reposition
14:31Anesthesia Ready Time
Patient Status: Ready for Prep and Positioning
14:34Pre-Op Checklist
Pt Identified/Chart Reviewed: Yes
Preop Evaluation Reviewed: Yes
Consent Signed: Yes
Correct Procedure: Yes
Procedure Site Marked: N/A
Allergies Addressed: Yes
Pulse Ox on and Functioning: Yes
Difficult Airway: No
Special Risk r/t Blood Loss: Yes
Equipment Checked: Yes
Pt Reassessed in OR: Yes
Acceptable for Anesthesia: Yes
Participated in Preop Timeout: Yes
Pre-Op Antibiotic TIME OUT
Antibiotic Given: Yes
Metferin or Ancef Given?: Yes
Discussion: Surgeon Notified
Discussion: No Further Orders
PreOp Antibiotic Start Time: Antibiotic < 1 Hour Pre-Incision
14:35Surgery Start
14:57Arterial Blood Gas
Results: pH - 7.36
Results: PCO2 _ mmHg - 49
Results: PO2 _ mmHg - 18
Results: cHCO3 _ mmol/L - 27.7
Results: BE _ mmol/L - 1.8
Results 2: K+ _ mmol/L - 4.5
Results 2: Ca _ mmol/L - 2.11
Results 2: Hgb _ g/dl - 8.4
15:24Note *
15:35Surgery Stop
16:00Arterial Line Placement
Preprocedural Time Out: Yes
Arterial Line Start Time: Time - 1600
Arterial Line Stop Time: Time - 1605
Skin Prep at Insertion Site: Chloraprep
Barrier Precautions: Large Drape
Barrier Precautions: Sterile Gloves
Barrier Precautions: Head Covering, Mask
Barrier Precautions: Sterile Field Maintained
Site: Right
Site: Radial
Type: Arrow - ANES RADIAL ART LINE INSERTION
Gauge: 20
# of Attempts: 2
Ultrasound Guided?: No
Pressure Line(s): Zeroed - ANES TRANSDUCER SINGLE
Verification: Arterial Blood Return
Verification: Appropriate Art. Waveform on Monitor
Dressing Applied: Op-Site
Dressing Applied: Secured with Tape
Dressing Applied: Hand/Wrist Support
Performed: By - Cho MD[5], Michael
16:04Patient Out of Room Time
Extubation
Pt Not Extubated: Extubation Criteria Not Met
Pt Not Extubated: Remains Intubated per Surgeon Request
16:11Transfer of Care
Transported to: ICU
Transported Via: Bed
Transfer Details: Ambu Bag Adult - ANES AMBU BAG DISPOSABLE ADULT
O2 Rate: _L/min - 10
Airway: Patent
LOC: Sedated
Arrival in PACU/PAR Time: Time - 1611
Patient Condition: Stable
Hand Off to RN: Yes
Hand Off to RN: See PACU Vital Signs
Hand Off to RN: SBAR Complete
PACU Vitals: SBP - 120
PACU Vitals: DBP - 52
PACU Vitals: Heart Rate - 102
PACU Vitals: Resp. Rate - 12
PACU Vitals: SpO2 _% - 100
PACU Temp: _ Fahrenheit - 98
16:23Anesthesia Stop Time *
Vital Sign: SpO2 - 100

Surgery / Anesthesia

1-Preanesthetic Evaluation H&P *NEW*

Patient: **CTIOWA, ONE** **MRN: 00-02-42-74-97** **FIN: 292408200232**
Age: **28 years** Sex: **Male** DOB: **10/20/1991**
Associated Diagnoses: **None**
Author: **Archambault MD[S], Francois J**

Preoperative Information
Scheduled Procedure Information:

Scheduled Surgery Date/Time: 09/08/2020 14:10
Surgery Location: MOR 34
Scheduled Primary Surgeon: Kopelman MD[S], Tammy R
Procedure: Thoracotomy
Modifier: w/Possible
Procedure: Laparotomy
5/20/19

Primary MD:

Anesthesia history:

Beta Blocker
NPO Status:
Compliant with ASA guidelines.

Health Status
Allergies:
No qualifying data available

Current medications:
No qualifying data available

Medications (20) Active
Scheduled: (13)
.Placeholder Bowel Elimination Orders 1 each, Misc, As Directed
.Placeholder Calcium Replacement Adult Plan 1 each, Misc, As Directed

Surgery / Anesthesia

.Placeholder Emergency Treatment Adult Protocols Medication 1 each, Misc, As Directed
.Placeholder Phosphorus Replacement Adult Plan 1 each, Misc, As Directed
.Placeholder Potassium/Magnesium Replacement Medications 1 each, Misc, As Directed
bacitracin oint tube 15 g 1 applTn, Topical, BID
Colace liq 100 mg/10 mL ud 100 mg 10 mL, Tube, BID
Lidoderm patch 5% 2 patch, Transdermal, Apply at HS + remove in AM
Pepcid vial 20 mg/2 mL 20 mg 2 mL, IV Push, BID
Peridex unit dose oral rinse 15 mL 15 mL, PO (by Mouth), BID
Peridex unit dose oral rinse 15 mL 15 mL, Swish & spit, BID
Rocephin inj 1 g 1 g 9.8 mL, IV Push, Q24HR
Senokot syrup 8.8 mg/5 mL 15 mL U/D cup 17.6 mg 10 mL, Tube, BID
Continuous: (3)
fentaNYL IV infusion 1,250 mcg + Premix Diluent 50 mL 50 mL, IV
Lactated Ringers 1,000 mL 1,000 mL, IV, 175 mL/hr
midazolam IV infusion 50 mg + Premix Diluent 50 mL 50 mL, IV
PRN: (4)
Haldol inj 5 mg/mL 5 mg 1 mL, IV Push, Q3HR
SEROquel tab 25 mg 25 mg 1 tab, Tube, Q6HR
Ultram tab 50 mg 25 - 50 mg, Tube, Q6HR
Versed inj 2 mg/2 mL 2.8 mg 2.8 mL, IV Push, Q10M

Histories

Past Surgical/Procedure Hx:
No qualifying data available.

Family History:
No family history recorded.

Social History:
Tobacco
Details: Unknown if ever smoked

Mental Health History:
No data entered

Review of Systems

ROS from Nursing Documentation:

Surgery / Anesthesia

TEETH:
DENTURES:
CARDIOVASCULAR HISTORY:
PULMONARY HISTORY:
GASTROINTESTINAL HISTORY:
GENIT/GYN HISTORY:
ENDOCRINE HISTORY:
HEMATOLOGY HISTORY:
CANCER HISTORY:
INTEGUMENTARY HISTORY:
NEUROLOGICAL HISTORY:
MUSCULOSKELETAL HISTORY:
INFECTIOUS DISEASE HISTORY:
ISOLATION PRECAUTIONS:

Physical Examination

VS/Measurements:

Vital Signs (last 24 hrs)			Last
Charted	Minimum	Maximum	
Temp	98.0 (SEP 08 13:37)	96.3 (SEP 07 23:37)	98.5 (SEP 08 12:21)
Heart Rate	119 (SEP 08 14:00)	86 (SEP 08 02:58)	C 155 (SEP 08 11:55)
Resp Rate	20 (SEP 08 14:00)	12 (SEP 08 04:15)	25 (SEP 08 10:00)
SBP	130 (SEP 08 14:00)	C 75 (SEP 08 07:00)	148 (SEP 08 13:37)
DBP	79 (SEP 08 14:00)	49 (SEP 08 09:00)	94 (SEP 08 13:37)
SpO2	100 (SEP 08 14:00)	20 (SEP 08 12:40)	100 (SEP 08 01:30)
Weight	70 (SEP 07 23:37)		

Weight	No result	
Height	180.3 cm 70.98 in	(08:30)

Body Mass Index: 21.5 kg/m2
Height - cm: 180.3 cm
Weight - kg: 70 kg

Surgery / Anesthesia

Weight - kg: 70 kg.
Airway:
, Distance, Normal temporomandibular joint mobility.
Mallampati classification: intubated.
Neck range of motion: Flexion (Limited), Extension (Limited), Rotation (Limited).
Heart: WNL.
Lung: decreased BS.
Physical Exam: Neck: c-collar.

Review / Management
Results review:
Labs (Last four charted values for the last six months)

WBC		5.9	(SEP 08)	11.2	(SEP 08)	H **19.6**	(SEP 08)		
Hgb	L **7.7**	(SEP 08)	L **11.7**	(SEP 08)		L **10.8**	(SEP 08)	L **12.7**	(SEP 08)
Hct	L **22.4**	(SEP 08)	L **34.9**	(SEP 08)		L **32.5**	(SEP 08)	39.2	(SEP 08)
Plt	L **96**	(SEP 08)	L **131**	(SEP 08)		208	(SEP 08)		
Na	138	(SEP 08)	140	(SEP 08)		136	(SEP 08)		
K	4.4	(SEP 08)	4.3	(SEP 08)		C **3.0**	(SEP 08)		
Cl	109	(SEP 08)	H **110**	(SEP 08)		108	(SEP 08)		
Cr	L **0.67**	(SEP 08)	0.76	(SEP 08)		0.81	(SEP 08)	1.13	(SEP 08)
BUN	11.0	(SEP 08)	10.0	(SEP 08)		10.0	(SEP 08)		
Glucose		H **113**	(SEP 08)	H **122**	(SEP 08)	H **272**	(SEP 08)		
Mg	L **1.5**	(SEP 08)							
Phos	L **2.1**	(SEP 08)							
Ca	L **8.2**	(SEP 08)	L **8.0**	(SEP 08)		10.3	(SEP 08)	L **7.6**	(SEP 08)
Troponin		H **1.40**	(SEP 08)						
Total CK		H **440**	(SEP 08)						
AST	H **112**	(SEP 08)							
ALT	H **61**	(SEP 08)	.						

Radiology Impressions:

Surgery / Anesthesia

COMPLETED RADIOLOGY IMAGING STUDIES:

DX Portable Chest
(09/08 1149): 1. No pneumothorax with left chest tube in place. 2. Stable additional support devices including an enteric tube and endotracheal tube. 3. Improvement of streaky left mid lung/basilar airspace opacities favoring atelectasis.

DX Portable Chest
(09/08 0422): 1. Left basilar atelectasis.

DX Shoulder Min 2 Views Lt
(09/08 0335): 1. Comminuted scapular fracture. 2. Surgical packing material along the left lateral chest wall.

DX Ankle Ap/Lat Lt
(09/08 0333): No Impression Available

DX Lower Leg Ap/Lat Lt
(09/08 0334): No Impression Available

DX Knee <3 Views Lt
(09/08 0335): No Impression Available

DX Femur Ap/Lat Lt
(09/08 0335): No Impression Available

DX Forearm Ap/Lat Lt
(09/08 0339): No Impression Available

DX Elbow Ap/Lat Lt
(09/08 0337): No Impression Available

DX Humerus Min 2 Views Lt
(09/08 0336): No Impression Available

DX Shoulder Min 2 Views Lt
(09/08 0335): No Impression Available

Surgery / Anesthesia

DX Portable Chest
(09/08 0233): 1. There is a left basilar pneumothorax and extensive subcutaneous air. 2. Left scapular fracture with associated chest wall hematoma and packing material in place.

CT Recon Pelvis
(09/08 0150): 1. No fracture. 2. Extensive left-sided posterior abdominal wall hematoma and subcutaneous air tracking down from the chest wall. 3. Small hematoma adjacent to the greater trochanter as well as some subcutaneous air in that location.

CT Thoraco Lumbar Recon
(09/08 0158): 1. No thoracic or lumbar spine fractures identified. 2. Large left-sided pneumothorax.

CT Thorax/Abd/Pelvis W/ Cont
(09/08 0140): 1. A large left basilar pneumothorax and associated atelectasis with a left chest tube in place. 2. There is a comminuted left clavicle fracture with associated large hematoma and packing material noted posteriorly. 3. Subcutaneous air extends down the left chest wall as well as anterior abdominal wall to the left groin. 4. There is a left buttocks hematoma posterior lateral to the left hip with some subcutaneous air in the posterior lateral soft tissues.

CT Face W/O Contrast
(09/08 0135): 1. Depressed left orbital floor fracture approximately 3 mm. 2. Thickened and sclerotic sphenoid bone more prominent on the right perhaps on the basis of fibrous dysplasia.

CT Cervical Spine W/O Contrast
(09/08 0148): 1. Sclerotic and sphenoid bone most compatible with fibrous dysplasia. 2. Comminuted scaphoid fracture with extends and surrounding hematoma and subcutaneous air. 3. No cervical spine fracture.

CT Head W/O Contrast
(09/08 0131): 1. Left periorbital soft tissue swelling with irregularity of the floor the orbit suspicious for an orbital floor fracture. 2. There is a sclerotic appearance to the sphenoid bone.

DX Portable Chest
(09/08 0001): 1. Prominent subcutaneous air on the left suspicious for a left basilar pneumothorax.

Plan

Surgery / Anesthesia

Anesthetic Assessment and Plan

ASA Classification

Class IV.

E.

Primary Anesthesia Technique

General: endotracheal tube.

Special Techniques

Standard.

Arterial line and CVC in situ.

Anesthesia Communication

PONV:

OSA:

Anesthetic plan, risks, benefits, and alternatives discussed with the patient and/or family

Risks discussed

Nausea.

Vomiting.

Headache.

Sore throat.

Dental injury.

Postop intubation.

Family/Guardian present

Informed consent was given

signed by next of kin/HCPOA/legal guardian

Signed on 09/08/2020 14:25 by
Archambault MD[S], Francois J

M OR Nursing Record

M OR Nursing Record Summary

Primary Physician:	Frisch MD[S], Harold M
Case Number:	M-2020-17543
Finalized Date/Time:	09/10/20 17:39:34
Pt. Name:	ROLLINS, ADAM ROY
D.O.B./Sex:	10/20/1991 Male
Med Rec #:	2427497

Surgery / Anesthesia

Physician:	CMEM MD, Physician
Financial #:	292408200232
Pt. Type:	I
Room/Bed:	K443/A
Admit/Disch:	09/08/20 01:46:45 -
Institution:	

MOR Catheters, Drains, Tubes

	Entry 1	Entry 2	Entry 3
Catheter, Drain, Tube, Packing	CATH FOLEY IN PLACE ON ARRIVAL	WOUND VAC	CHEST TUBE
Quantity	1	1	2
Location	bladder	abdomen	left side chest
Present on Arrival?	Yes	Yes	Yes
Inserted By			
Removed at end of Case?	No	Yes	No
Last Modified By:	Linton RN, Anna E 09/09/20 09:14:00	Linton RN, Anna E 09/09/20 13:16:28	Linton RN, Anna E 09/09/20 09:15:43

	Entry 4
Catheter, Drain, Tube, Packing	DRAIN INCS 19FR .25IN BRD SIL 4
Quantity	2
Location	left scapula
Present on Arrival?	No
Inserted By	Kopelman MD[S], Tammy R
Removed at end of Case?	No
Last Modified By:	Linton RN, Anna E 09/09/20 14:01:34

MOR Case Times

	Entry 1		
Room			
Room Ready	09/09/20 07:22:00		
Patient In Room Time	09/09/20 07:43:00	Surgery Start Time	09/09/20 08:26:00
Surgery Stop Time	09/09/20 14:00:00	Patient Out Room Time	09/09/20 14:24:00
Clean - Up			
Closing	09/09/20 13:16:00		
Last Modified By:	Linton RN, Anna E 09/09/20 14:22:38		

5hrs, 58mins

MOR Case Attendance

	Entry 1	Entry 2	Entry 3
Case Attendee	Frisch MD[S], Harold M	Kopelman MD[S], Tammy R	Simons MD[S], John P
Role Performed	Surgeon	Surgeon - Other DO NOT USE	Anesthesiologist
Relief Reason			
Signing Attendee	No	No	No

Surgery / Anesthesia

Description	SCRW CRTX 2.4 X 40 MM 4 HD S	SCRW CRTX 3.5 X 20 2.5 MM S	SCRW CRTX 3.5 X 22 2.5 MM S
Quantity	1	4	3
Catalog Number	201.670	204.820	204.822
Manufacturer	synthes	synthes	synthes
Implant Site	Arm L Upper	Arm L Upper	Arm L Upper
Implant Inventory - Detail			
Expiration Date			
Lot Number			
Load Number	6-10 1 Sep 2020	6-10 1 Sep 2020	6-10 1 Sep 2020
Serial Number			
Last Modified By:	Linton RN, Anna E 09/09/20 10:51:46	Linton RN, Anna E 09/09/20 10:51:46	Linton RN, Anna E 09/09/20 10:51:46
	Entry 10	**Entry 11**	**Entry 12**
Implant Identification			
Description	SCRW CRTX 3.5 X 28 2.5 MM S	SCRW LKNG ST SD 3.5 X 18 MM S	PLT DCP 7 HL 98 MM SMALL
Quantity	1	4	1
Catalog Number	204.828	212.105	223.571
Manufacturer	synthes	SYNTHES LOCKIN SMALL	SYNTHES LOCKING
		FRAG SET -002	FRAG TRAY - 002
Implant Site	Arm L Upper	Arm L Lower	Arm L Lower
Implant Inventory - Detail			
Expiration Date			
Lot Number		4 3 08SEP2020	4 3 08SEP 2020
Load Number	6-10 1 Sep 2020		
Serial Number			
Last Modified By:	Linton RN, Anna E 09/09/20 10:51:46	Linton RN, Anna E 09/09/20 10:51:46	Linton RN, Anna E 09/09/20 10:51:46
	Entry 13		
Implant Identification			
Description	SCRW CRTX 3.5 X 16 2.5 MM S		
Quantity	2		
Catalog Number	204.816		
Manufacturer	synthes		
Implant Site	Arm L Upper		
Implant Inventory - Detail			
Expiration Date			
Lot Number			
Load Number	6-10 1 Sep 2020		
Serial Number			
Last Modified By:	Linton RN, Anna E 09/09/20 10:51:46		

16 Screws all in the patients left arm

Surgery / Anesthesia

MOR Other Equipment

	Entry 1		
Equipment Type	SCDs	Setting	DEFAULT ON
Outcome Met	Yes		
Last Modified By:	Linton RN, Anna E 09/09/20 09:52:34		

Post-Care Text:
The Patient is Free from Signs and Symptoms of Equipment Injury

MOR Dressing

	Entry 1	Entry 2	Entry 3
Type	Xeroflo, 4 X 4, Cast Padding, Elastic Wrap (ACE)	4 X 4, Medipore tape	Primapore
Location	left arm	left shoulder - drain 2x	abdomen
Comments	fluffs	chest tubes re-dressed with xeroform, drain sponges, and medipore tape	
For spine cases, Number of Levels Fused?			
Wound Closure Type?	Primary	Primary	Primary
Last Modified By:	Linton RN, Anna E 09/09/20 13:27:41	Linton RN, Anna E 09/09/20 14:07:38	Linton RN, Anna E 09/09/20 13:27:41

MOR Departure from OR

	Entry 1		
Via	Unit Bed	Destination	Neuro ICU
Transport with Identification Bracelet	Yes	Outcome Met	Yes
Last Modified By:	Linton RN, Anna E 09/09/20 14:00:55		

Post-Care Text:
The Patient is Free from Signs and Symptoms of Injury Related to Transfer/Transport

MOR Safety Checklist - Time Out

Pre-Care Text:
Patient Safety First. Do Not Proceed until all elements of the Time Out are verbalized. All team members must participate and fully agree to each statement referenced.

	Entry 1	Entry 2	Entry 3
Antibiotic was Given If Injection Required Prior to Surgical Incision a Brief Time Out Was Completed for Site Verification	Yes n/a	Yes n/a	Yes n/a

Surgery / Anesthesia

Compared to Consent and Site Marking?			
Injection Time Out Time			
Injection Medication Verified?	n/a	n/a	n/a
Surgical Time Out Time	09/09/20 08:25:00	09/09/20 13:03:00	09/09/20 12:20:00
Surgeon/Proceduralist Ensures all Questions/Concerns Addressed?	Yes	Yes	Yes
Surgeon/Proceduralist Initiates the Time Out	Yes	Yes	Yes
All Team Member are Introduced?	Yes	Yes	Yes
Surgeon/Proceduralist Ensures all Activity Ceases?	Yes	Yes	Yes
Patient ID Confirmed Using 2 Identifiers?	Yes	Yes	Yes
Surgeon/Proceduralist Ensures all Team Members Are Engaged	Yes	Yes	Yes
Procedure Confirmed with Consent?	Yes	Yes	Yes
Correct Position Confirmed?	Yes	Yes	Yes
Correct Site/Side Confirmed if Required?	Yes	Yes	Yes
All Equipment, Instruments Implants Available?	Yes	Yes	Yes
Site Marking Verified	Yes	n/a	n/a
Necessary Images Available, Displayed?	Yes	Yes	Yes
PROCEDURE IS NOT STARTED UNTIL ALL QUESTIONS/CONCERNS ARE RESOLVED	Yes	Yes	Yes
Last Modified By:	Linton RN, Anna E 09/09/20 13:10:21	Linton RN, Anna E 09/09/20 13:10:21	Linton RN, Anna E 09/09/20 13:10:21

General Comments:
Individual time outs performed at start of left arm procedures, left scapula I&D, and laparotomy.

MOR Safety Checklist Debrief

Entry 1

Surgery / Anesthesia

Procedure Name, Diagnosis Verified	Yes	Recovery Concerns Addressed?	Yes
Specimen Labels Read/Confirmed with Surgeon/Proceduralist?	n/a	Medications Secured and Properly Disposed?	n/a
Counts Status Verified with Surgeon/Proceduralist?	Yes	New Orders Confirmed? (eg Radiology, Labs, Blood, etc)	Yes
Wound Class Verified	Yes	Equipment or Instrument Concerns Addressed?	Yes
Surgeon Anesthesia Confirmation			
Urine Output	Yes	EBL	Yes
Outcome Met	Yes		
Last Modified By:	Linton RN, Anna E 09/09/20 14:00:51		

Case Comments

<None>

Finalized By: Wankel RN, Daniel

Document Signatures

Signed By:
Linton RN, Anna E 09/09/20 14:22
Wankel RN, Daniel 09/10/20 17:39

Unfinalized History

Date/Time	Username	Reason for Unfinalizing	Freetext Reason for Unfinalizing
09/10/20 17:38	SURDPW	Modify Pick List	

M OR Nursing Record

M OR Nursing Record Summary

Primary Physician:	Kopelman MD[S], Tammy R
Case Number:	M-2020-17548
Finalized Date/Time:	09/08/20 16:42:38
Pt. Name:	CTIOWA, ONE
D.O.B./Sex:	10/20/1991 Male
Med Rec #:	2427497
Physician:	CMEM MD, Physician

Surgery / Anesthesia

Financial #:	292408200232
Pt. Type:	I
Room/Bed:	K443/A
Admit/Disch:	09/08/20 01:46:45 -
Institution:	

MOR Catheters, Drains, Tubes

	Entry 1	Entry 2	Entry 3
Catheter, Drain, Tube, Packing	CATH FOLEY IN PLACE ON ARRIVAL	CHEST TUBE IN PLACE UPON ARRIVAL	CATH THORACIC 28 FR
Quantity	1	1	1
Location	Urinary bladder	LEFT CHEST	LEFT chest
Present on Arrival?	Yes	Yes	No
Inserted By			Kopelman MD[S], Tammy R
Removed at end of Case?	No	No	No
Last Modified By:	Pearson RN, Sherilyn S	Pearson RN, Sherilyn S	Pearson RN, Sherilyn S
	09/08/20 15:06:53	09/08/20 15:06:53	09/08/20 16:01:22

	Entry 4	Entry 5	Entry 6
Catheter, Drain, Tube, Packing	DRAIN CHEST PLEUR-EVAC ADLT	DSNG ABD V.A.C. SENSA TRAC	CANNISTER INFO 500 CC
Quantity	1	1	1
Location		Abdomen	
Present on Arrival?	No	No	No
Inserted By	Kopelman MD[S], Tammy R	Kopelman MD[S], Tammy R	
Removed at end of Case?	No	No	No
Last Modified By:	Pearson RN, Sherilyn S	Pearson RN, Sherilyn S	Pearson RN, Sherilyn S
	09/08/20 16:01:22	09/08/20 16:16:16	09/08/20 16:17:56

MOR Case Times

	Entry 1		
Room			
Room Ready	09/08/20 14:00:00		
Patient In Room Time	09/08/20 14:22:00	Surgery Start Time	09/08/20 14:35:00
Surgery Stop Time	09/08/20 15:35:00	Patient Out Room Time	09/08/20 16:04:00
Clean - Up			
Last Modified By:	Pearson RN, Sherilyn S 09/08/20 16:02:46		

MOR Case Attendance

	Entry 1	Entry 2	Entry 3
Case Attendee	Kopelman MD[S], Tammy R	Pearson RN, Sherilyn S	Jacobin RN, Thomas A
Role Performed	Surgeon	RN Circulator	RN Second Circulator
Relief Reason			

Surgery / Anesthesia

Signing Attendee	No	No	No
Time In	09/08/20 14:22:00	09/08/20 14:22:00	09/08/20 14:22:00
Time Out	09/08/20 16:04:00	09/08/20 16:04:00	09/08/20 15:00:00
Procedure	Laparotomy, Thoracotomy		
Last Modified By:	Pearson RN, Sherilyn S	Pearson RN, Sherilyn S	Pearson RN, Sherilyn S
	09/08/20 16:25:56	09/08/20 16:25:56	09/08/20 16:25:56
	Entry 4	**Entry 5**	**Entry 6**
Case Attendee	Sellars RN, Samantha C	Ordenes CST, Vanessa M	Arrowood , Stephanie
Role Performed	RN Second Circulator	Surgical Technician	Surgical Tech Second Scrub
Relief Reason			
Signing Attendee	No	No	No
Time In	09/08/20 14:22:00	09/08/20 14:22:00	09/08/20 14:22:00
Time Out	09/08/20 16:04:00	09/08/20 16:04:00	09/08/20 16:04:00
Procedure			
Last Modified By:	Pearson RN, Sherilyn S	Pearson RN, Sherilyn S	Pearson RN, Sherilyn S
	09/08/20 15:01:43	09/08/20 16:25:56	09/08/20 16:25:56
	Entry 7	**Entry 8**	**Entry 9**
Case Attendee	Owensby CST, Cynthia	Merino MD[R], Timothy J	Waldroup CRNA, Amber
Role Performed	Surgical Tech Second Scrub	Resident	CRNA
Relief Reason			
Signing Attendee	No	No	No
Time In	09/08/20 14:22:00	09/08/20 14:22:00	09/08/20 14:22:00
Time Out	09/08/20 16:04:00	09/08/20 16:04:00	09/08/20 16:04:00
Procedure			
Last Modified By:	Pearson RN, Sherilyn S	Pearson RN, Sherilyn S	Pearson RN, Sherilyn S
	09/08/20 16:25:56	09/08/20 16:25:56	09/08/20 16:25:56
	Entry 10		
Case Attendee	Decker MD[R], Kathryn T		
Role Performed	Resident		
Relief Reason			
Signing Attendee	No		
Time In	09/08/20 14:22:00		
Time Out	09/08/20 16:04:00		
Procedure			
Last Modified By:	Pearson RN, Sherilyn S 09/08/20 16:25:56		

MOR Case Data

	Entry 1		
OR	MOR 34	**Specialty**	Trauma Surgery
ASA Class	4E Emergency Severe Disease Life at Risk	**Wound Class**	1 - Clean
Case Level	SIntL1 - Intermediate	**Preoperative**	Abdomianal trauma

Surgery / Anesthesia

	Level 1	Diagnosis	
Postop Same As Preop	No	Postoperative Diagnosis	Abdomianal trauma
Last Modified By:	Pearson RN, Sherilyn S 09/08/20 14:53:55		

MOR Procedure

	Entry 1	Entry 2
Procedure	Laparotomy	Thoracotomy
Modifiers		
Extra Detail Text	Placement of Abthera negative pressure dressing	Placement of 2nd chest tube
Primary Procedure	Yes	No
Primary Surgeon	Kopelman MD[S], Tammy R	Kopelman MD[S], Tammy R
Start	09/08/20 14:35:00	09/08/20 14:35:00
Stop	09/08/20 15:35:00	09/08/20 15:35:00
Anesthesia Type	General Anesthesia	General Anesthesia
Surgical Service	Trauma Surgery	Trauma Surgery
Conversion to Open from Laparoscopy/Robotic?		
Conversion Start Time		
Last Modified By:	Pearson RN, Sherilyn S 09/08/20 16:18:42	Pearson RN, Sherilyn S 09/08/20 16:26:28

MOR Anesthesia Time Out (Pre Induction)

Pre-Care Text:
A.20.1 Verifies consent for planned procedure

	Entry 1		
Time-Out Performed	09/08/20 14:22:00	Anesthesia Time Out Not Done Due to Emergent Case	Yes
Preop Checklist Completed?	Yes	Anes Machine Safety Check Completed?	Yes
Patient ID Confirmed Using 2 Identifiers?	Yes	All Equipment Instruments Inplants Available?	Yes
All Allergies Confirmed?	Yes	Anesthesia Risks Discussed?	Yes
Surgeon/Proceduralist Confirmed?	Yes	Is Blood Available if Needed?	Yes
Procedure and Site Confirmed?	Yes	Other Procedures Needed Discussed Prior to Sedation?	Yes
Last Modified By:	Pearson RN, Sherilyn S 09/08/20 14:43:37		

MOR Fire Risk Assessment

Pre-Care Text:

Surgery / Anesthesia

https://mod.missionhealth.org/wp-content/uploads/2020/03/Surgical-Fire-Risk-Assessment-Tool.pdf

	Entry 1		
Procedure in Oropharynx or Above Xiphoid?	Yes	**Open Oxygen or Nitrous Oxide being Administered?**	Yes
ESU, Laser or Fiber Optic Light being Used?	Yes	**Total Fire Safety Score**	3
Last Modified By:	Pearson RN, Sherilyn S 09/08/20 14:44:53		

General Comments:
Possible thoracotomy.

MOR Family Notification

	Entry 1
Family Notification	MD to speak with family at end of case.
Last Modified By:	Pearson RN, Sherilyn S 09/08/20 14:46:03

MOR Patient Positioning

	Entry 1		
Body Position	Supine on OR Table	**Head Positioner**	Pillow Under Head
Right Arm Position	On Padded Armboard with Safety Strap, Abducted Less Than 90 Degrees	**Left Arm Position**	On Padded Armboard with Safety Strap, Abducted Less Than 90 Degrees
Right Leg Position	Straight, Leg Uncrossed	**Left Leg Position**	Straight, Leg Uncrossed
Positioning Devices	Safety Strap Across Upper Thighs	**Positioning and Comfort Statements**	Position Approved by Surgeon, Safety strap re-checked after induction, Obtain Transfer Assistance, Position Approved by Anesthesia, Position Supervised by Anesthesia, Position Supervised by Resident, Position Supervised by Surgeon, Warm Blanket Applied Over Patient, Patient in Physiological Alignment, Raise Room

Surgery / Anesthesia

Temperature

Outcome Met	Yes
Last Modified By:	Pearson RN, Sherilyn S 09/08/20 16:25:41

Post-Care Text:
The Patient is Free of Signs and Symptoms of Injury Related to Positioning

MOR Thermoregulation

	Entry 1		
Warming Device	BAIR HUGGER	Outcome Met	Yes
Last Modified By:	Pearson RN, Sherilyn S 09/08/20 15:00:11		

Post-Care Text:
The Patient is At or Returning to Normothermia at the Conclusion of the Immediate Postoperative Period
General Comments:
Lower Bair

MOR Skin Prep

	Entry 1		
Prep Area	Abdomen and chest	Prep Agents	Chloraprep
Prep Performed By:	Pearson RN, Sherilyn S, Jacobin RN, Thomas A	If alcohol prep used, prepped area was dry and non-pooling prior to use of electro-cautery or laser.	Yes
Hair Removal Methods	No Hair Removal		
Outcome Met	Yes		
Last Modified By:	Pearson RN, Sherilyn S 09/08/20 15:02:06		

Post-Care Text:
The Patient is Free from Signs and Symtoms of Chemical Injury

MOR Irrigation Intake

	Entry 1	Entry 2
Solution Used for Reconstitution /Washing/Rinsing of Tissue, If yes, complete Lot and Expiration Fields:	No	No
Irrigant	SOLN SODIUM CHLOR 1000 ML BTL	SOLN SODIUM CHLOR 500 ML BTL
Nbr of Containers	4	6
Lot Number		
Expiration Date		
Please document Additives in the Medication segment